

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12953

CERTIFICATE OF DEATH

12939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie ELIZABETH Anthony</u>		4. DATE OF DEATH Month Day Year <u>Nov. 27 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2-1879</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Chesapeake 2d Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James S. Roe</u>		14. MOTHER'S MAIDEN NAME <u>Roxanna Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Joseph & Anthony Queenstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 1951, to <u>Nov.</u> , 1959, that I last saw the deceased alive on <u>Nov. 20</u> , 1959, and that death occurred at <u>1:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>12/7/59</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.			
PHYSICIAN'S NAME (Type) <u>IRVIN G HOYT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 30 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's Church</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Baithy, Baith Bros</u> ADDRESS <u>Chesapeake 2d Co. Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Ruthsburg</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Goldsboro, Md.</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Noble</u> Middle <u>Bickling</u> Last <u>—</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1959</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Oct 30, 1897</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>62 yrs.</u> IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles Bickling</u>				14. MOTHER'S MAIDEN NAME <u>Rose Guesford</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-32-9683</u>		17. INFORMANT <u>Lester Bickling</u> Address <u>Greensboro, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Injury</u> <u>816x</u> DUE TO <u>Automobile Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Two-car collision</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11-7-59</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hwy.</u>		20f. (City or town) <u>hr. Centreville</u> (County) <u>QA</u> (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D. EXAMINER'S NAME (Type) <u>Irvin G. Hoyt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) <u>Greensboro, Maryland</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Boulaia</u> ADDRESS <u>Greensboro</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>NOV 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar, and 3 to burial, cremation, or removal.

Items 20421 from E. Sun. - 11/9/59
as.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12955

12941

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARCLAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>EMMA</u> Last <u>BOOKER</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 19-1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK JARMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY BENTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MISS GLADYS BOOKER = BARCLAY MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>Chronic myocarditis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>59</u> , to <u>Nov. 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>59</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/7/59</u>	
PHYSICIAN'S NAME (Type) <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 9</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SUDLERSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>SUDLERSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

1945

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1910		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. EDUCATION High School		9. RELIGION Methodist		10. RACE White	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH Apr 4, 1968		15. TIME OF DEATH 10:00 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF REGISTRAR J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. COUNTY Baltimore		22. CITY Baltimore		23. STATE Maryland		24. ZIP CODE 21201		25. OTHER None	

NOT A VALID DOCUMENT FOR ESTABLISHING RESIDENCY OR CITIZENSHIP OF THE UNITED STATES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Queenstown</u> c. LENGTH OF STAY IN 1b <u>7 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>STEADMAN</u> <u>Cross</u>				4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>4</u> <u>1959</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11 - 1866</u>		9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>				11. BIRTHPLACE (State or foreign country) <u>Queenstown Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Cross</u>						14. MOTHER'S MAIDEN NAME <u>Annie Sparks</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>William Wm Cross Queenstown Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____		(County) _____		(State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>11/5/59</u>			
EXAMINER'S NAME (Type) <u>Irvin G. Hoyt MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov - 7 - 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake</u>				22d. LOCATION (City, town, or county) <u>Chesapeake</u>				(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm A. Borton & Borton Bros</u>						ADDRESS <u>Chesapeake Md</u>						24a. REC'D BY REGISTRAR <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Irvin G. Hoyt</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX _____		3. AGE _____	
4. OCCUPATION _____		5. PLACE OF BIRTH _____		6. DATE OF BIRTH _____	
7. STREET ADDRESS _____		8. CITY AND COUNTY _____		9. STATE _____	
10. MARITAL STATUS _____		11. COLOR _____		12. HEIGHT _____	
13. WEIGHT _____		14. TEMPERATURE _____		15. PULSE _____	
16. RESPIRATION _____		17. BLOOD PRESSURE _____		18. OTHER _____	
19. CAUSE OF DEATH _____					
20. MANNER OF DEATH _____					
21. SIGNATURE OF EXAMINER _____					
22. DATE _____					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12943

12957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine</u> <u>B.</u> <u>Everett</u>				4. DATE OF DEATH Month Day Year <u>November</u> <u>18</u> <u>1959</u>			
5. SEX <u>Fem.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27, 1909</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry O. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Elliott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>220-01-7372</u>		17. INFORMANT Address <u>Mr. Daniel Everett-Centreville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arthroscopic pericarditis</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Nov 19, 1959</u>			
EXAMINER'S NAME (Type) <u>C. R. Layton</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 21</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u>		22d. LOCATION (City, town, or County) (State) <u>CENTREVILLE</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edgar L. Lane - Church Hill, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file or for a burial, cremation, or removal. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 4 & 22 Film G253 12/4/59 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

12944

12958

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fordtown</u>		c. LENGTH OF STAY IN 1b <u>5 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 98 E Rt 1</u>		d. STREET ADDRESS <u>Stevensville, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>Ford</u> Last <u>Ford</u>		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Pierce</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Clayton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Betha Dyth, Stevensville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> 334X DUE TO <u>Previous stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Stroke July 1959</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4 mos</u> <u>Some year</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>—</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 25, 1959 to Nov 28, 1959</u> , that I last saw the deceased alive on <u>Nov 25/59</u> , and that death occurred at <u>10 A M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		ADDRESS (Street, city or town, state) <u>Millington Md</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		DATE SIGNED <u>11/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Battleneck Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Ashby, Easton, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>DEC 1-59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Miller</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12959

CERTIFICATE OF DEATH

12945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEMUEL Y. GARDNER</u>				4. DATE OF DEATH <u>NOV. 21 19 59</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 17-1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATER MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL GARDNER</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE EATON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-07-9674</u>		17. INFORMANT <u>MRS. LEMUEL GARDNER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC Shock</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY Thrombosis</u> DUE TO (c) <u>CORONARY ARTERY. DISEASE</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>11-21</u> , 19 <u>59</u> , to <u>11-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-21</u> , 19 <u>59</u> , and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Balodi</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>11-23-59</u>			
PHYSICIAN'S NAME (Type) <u>LUIGI BALDI, M.D.</u>				<u>CHESTER, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>NOV. 24</u>		<u>CHESTER FIELD</u>		<u>CENTREVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard L. Lane Church Hill Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

1955

DECEASED NAME SAMUEL CARPENTER		SEX Male	
DATE OF BIRTH 1-1-1904		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Carpenter		MARITAL STATUS Married	
DATE OF DEATH 1-1-1955		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Myocardial Infarction	
MEDICAL HISTORY None		SURVIVAL None	
SIGNATURE OF PHYSICIAN J. Edgar Smith		SIGNATURE OF REGISTRAR J. Edgar Smith	
SIGNATURE OF WITNESS J. Edgar Smith		SIGNATURE OF WITNESS J. Edgar Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12960

CERTIFICATE OF DEATH

Reg. Dist. No.

12946

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Skinner Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First E. Middle HANSEN Last		4. DATE OF DEATH Month November Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1867
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Helen Bull, Address Sudlersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pericarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Ribs - Spontaneous		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 2 , 19 59 , to Nov 3 , 19 59 , that I last saw the deceased alive on Nov 1 , 19 59 , and that death occurred at 1 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. METCALFE M.D.		ADDRESS (Street, city or town, state) Sudlersville, Md. DATE SIGNED Nov 11/1959	
PHYSICIAN'S NAME (Type) C. H. METCALFE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward H. Hallowell ADDRESS Mellington, Md.		24a. REC'D BY REGISTRAR DATE NOV 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12961
CERTIFICATE OF DEATH

12947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY QUEEN ANNE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE	
c. LENGTH OF STAY IN lb 7 yrs.		d. STREET ADDRESS WHARF LANE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHARF LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH IRENE HENRY		4. DATE OF DEATH NOVEMBER 8, 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/91
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME AMOS TAYLOR KENDALL		14. MOTHER'S MAIDEN NAME MARY ELIZABETH TEAT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LYDIA J. BRADFORD		Address 300 BASIN ROAD WILMINGTON BAY MANOR NEWCASTLE DE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 581.0 DUE TO CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 5 MONTHS DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INFECTED DECUBITUS ULCER			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/28/1959 to 11/8/1959 , that I last saw the deceased alive on 11/7/1959 , and that death occurred at 4:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Kent Young		ADDRESS (Street, city or town, state) 105 Chestersfield Ave. Centreville, Maryland	
PHYSICIAN'S NAME (Type) J. Kent Young, M.D.		DATE SIGNED NOV 13 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF NOV-11-59	
22c. NAME OF CEMETERY OR CREMATORY RIVER VIEW CEMETERY		22d. LOCATION (City, town, or county) (State) Wilmington Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE William Butler		24a. RECEIVED BY REGISTRAR NOV 13 59	
ADDRESS William Butler		24b. REGISTRAR'S SIGNATURE William S. Kline	

CENTRAL STATE OF DEATH

1998

STATE OF CALIFORNIA

DEPARTMENT OF HEALTH SERVICES

DATE OF BIRTH: 10/10/1940
DATE OF DEATH: 10/10/1940
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SEX: [illegible]
RACE: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
RELIGION: [illegible]
MARRIAGE: [illegible]
SIGNED: [illegible]
DATE: [illegible]

12962

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>		c. LENGTH OF STAY in 1b <u>25 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>/</u>				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Melvin</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25, 1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>/</u>		11. BIRTHPLACE (State or foreign country) <u>Chesler Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Lowery</u>				14. MOTHER'S MAIDEN NAME <u>Marie Louisa White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Louise Mitchell Price Stevensville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper gastro-intestinal bleeding cause</u> <u>578X</u> DUE TO <u>intermittent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerotic heart disease</u> DUE TO (c) <u>acute obstructive hepatitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>5 years</u> <u>1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Serivility uterine prolapse 3rd degree</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1954</u> to <u>Nov. 23, 1959</u> , that I last saw the deceased alive on <u>Nov. 23, 1959</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville Md.</u> DATE SIGNED <u>Nov. 23, 59</u>			
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAIER STEVENSVILLE, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>302 25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1965

DECEASED'S NAME [Handwritten: <i>John Doe</i>]		SEX [Handwritten: <i>Male</i>]		AGE [Handwritten: <i>45</i>]	
DATE OF DEATH [Handwritten: <i>Jan 15 1965</i>]		TIME OF DEATH [Handwritten: <i>10:30 AM</i>]		PLACE OF DEATH [Handwritten: <i>Home</i>]	
DECEASED'S ADDRESS [Handwritten: <i>123 Main St, Baltimore, MD</i>]		DECEASED'S OCCUPATION [Handwritten: <i>Teacher</i>]		DECEASED'S MARITAL STATUS [Handwritten: <i>Married</i>]	
DECEASED'S BIRTH DATE [Handwritten: <i>Jan 15 1920</i>]		DECEASED'S BIRTH PLACE [Handwritten: <i>Baltimore, MD</i>]		DECEASED'S RACE [Handwritten: <i>White</i>]	
DECEASED'S RELIGION [Handwritten: <i>Catholic</i>]		DECEASED'S EDUCATION [Handwritten: <i>High School</i>]		DECEASED'S SERVICE [Handwritten: <i>None</i>]	
DECEASED'S SOCIAL SECURITY NUMBER [Handwritten: <i>123-45-6789</i>]		DECEASED'S MOTHER'S MAIDEN NAME [Handwritten: <i>Johns</i>]		DECEASED'S FATHER'S NAME [Handwritten: <i>John Doe</i>]	
DECEASED'S MOTHER'S BIRTH DATE [Handwritten: <i>Jan 15 1915</i>]		DECEASED'S MOTHER'S BIRTH PLACE [Handwritten: <i>Baltimore, MD</i>]		DECEASED'S MOTHER'S RACE [Handwritten: <i>White</i>]	
DECEASED'S MOTHER'S RELIGION [Handwritten: <i>Catholic</i>]		DECEASED'S MOTHER'S EDUCATION [Handwritten: <i>High School</i>]		DECEASED'S MOTHER'S SERVICE [Handwritten: <i>None</i>]	
DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER [Handwritten: <i>123-45-6789</i>]		DECEASED'S MOTHER'S MOTHER'S MAIDEN NAME [Handwritten: <i>Johns</i>]		DECEASED'S MOTHER'S FATHER'S NAME [Handwritten: <i>John Doe</i>]	
DECEASED'S MOTHER'S BIRTH DATE [Handwritten: <i>Jan 15 1910</i>]		DECEASED'S MOTHER'S BIRTH PLACE [Handwritten: <i>Baltimore, MD</i>]		DECEASED'S MOTHER'S RACE [Handwritten: <i>White</i>]	
DECEASED'S MOTHER'S RELIGION [Handwritten: <i>Catholic</i>]		DECEASED'S MOTHER'S EDUCATION [Handwritten: <i>High School</i>]		DECEASED'S MOTHER'S SERVICE [Handwritten: <i>None</i>]	
DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER [Handwritten: <i>123-45-6789</i>]		DECEASED'S MOTHER'S MOTHER'S MAIDEN NAME [Handwritten: <i>Johns</i>]		DECEASED'S MOTHER'S FATHER'S NAME [Handwritten: <i>John Doe</i>]	

11

12

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS DIVISION. IT IS NOT VALID FOR OTHER PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12963

CERTIFICATE OF DEATH

Reg. Dist. No.

12949

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Golden</u> Middle <u>Millie</u> Last <u>Meredith</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Cromwell</u>		14. MOTHER'S MAIDEN NAME <u>Millie Castor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-1391</u>	
17. INFORMANT <u>Leola Cornish</u>		Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hyper Tension</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>? yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> , to <u>Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 23</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queens Town, Md.</u> DATE SIGNED <u>11/24/59</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		M.D. <u>—</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Kent Island Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Nr. Chester, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Nelson</u>		24a. REC'D BY REGISTRAR <u>NOV 27 59</u>	
ADDRESS <u>100 Brantley Ave., Balto.</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

STATE OF TEXAS

1933

County of _____ State of Texas
I, _____
do hereby certify that _____
is the true and correct copy of _____
as the same appears from the _____
of _____
this _____ day of _____ 1933.
Attest my hand and seal of office this _____ day of _____ 1933.

County Clerk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12964

CERTIFICATE OF DEATH

12950

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD # 1 Chestertown	c. LENGTH OF STAY in 1b lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RFD # 1 Chestertown, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home		d. STREET ADDRESS RFD # 1	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Carrie Middle L. Last Miller		4. DATE OF DEATH Nov. 7, 1959 Day 19 Year 19	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 3 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife and		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-18-6630	
17. INFORMANT Emma Miller		Address RFD # 1 Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO (PROBABLY SUBARACHNOID HEMORRHAGE) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DIS. DUE TO GENERALIZED ARTERIOSCLEROSIS (c) GENERALIZED ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 11 p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-11 , 19 59 , to 10-22 , 19 59 , that I last saw the deceased alive on 10-22 , 19 59 , and that death occurred at 8 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Paul Ross		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) Harry Paul Ross M. D.		DATE SIGNED Nov. 9, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/12/59	22c. NAME OF CEMETERY OR CREMATORY Rich Neck Hall Cem.	22d. LOCATION (City, town, or county) (State) near Church Hill, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE NOV 12 '59
		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1880		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Roman Catholic		10. EDUCATION High School	
11. DECEASED'S RESIDENCE 1234 E. BALTIMORE ST. BALTIMORE, MARYLAND		12. DECEASED'S USUAL PLACE OF RESIDENCE Same as residence		13. DECEASED'S USUAL PLACE OF EMPLOYMENT None		14. DECEASED'S USUAL PLACE OF DEATH Home		15. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
16. DECEASED'S USUAL PLACE OF DEATH Home		17. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		18. DECEASED'S USUAL PLACE OF DEATH Home		19. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		20. DECEASED'S USUAL PLACE OF DEATH Home	
21. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		22. DECEASED'S USUAL PLACE OF DEATH Home		23. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		24. DECEASED'S USUAL PLACE OF DEATH Home		25. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
26. DECEASED'S USUAL PLACE OF DEATH Home		27. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		28. DECEASED'S USUAL PLACE OF DEATH Home		29. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		30. DECEASED'S USUAL PLACE OF DEATH Home	
31. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		32. DECEASED'S USUAL PLACE OF DEATH Home		33. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		34. DECEASED'S USUAL PLACE OF DEATH Home		35. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
36. DECEASED'S USUAL PLACE OF DEATH Home		37. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		38. DECEASED'S USUAL PLACE OF DEATH Home		39. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		40. DECEASED'S USUAL PLACE OF DEATH Home	
41. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		42. DECEASED'S USUAL PLACE OF DEATH Home		43. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		44. DECEASED'S USUAL PLACE OF DEATH Home		45. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
46. DECEASED'S USUAL PLACE OF DEATH Home		47. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		48. DECEASED'S USUAL PLACE OF DEATH Home		49. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		50. DECEASED'S USUAL PLACE OF DEATH Home	
51. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		52. DECEASED'S USUAL PLACE OF DEATH Home		53. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		54. DECEASED'S USUAL PLACE OF DEATH Home		55. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
56. DECEASED'S USUAL PLACE OF DEATH Home		57. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		58. DECEASED'S USUAL PLACE OF DEATH Home		59. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		60. DECEASED'S USUAL PLACE OF DEATH Home	
61. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		62. DECEASED'S USUAL PLACE OF DEATH Home		63. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		64. DECEASED'S USUAL PLACE OF DEATH Home		65. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
66. DECEASED'S USUAL PLACE OF DEATH Home		67. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		68. DECEASED'S USUAL PLACE OF DEATH Home		69. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		70. DECEASED'S USUAL PLACE OF DEATH Home	
71. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		72. DECEASED'S USUAL PLACE OF DEATH Home		73. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		74. DECEASED'S USUAL PLACE OF DEATH Home		75. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
76. DECEASED'S USUAL PLACE OF DEATH Home		77. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		78. DECEASED'S USUAL PLACE OF DEATH Home		79. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		80. DECEASED'S USUAL PLACE OF DEATH Home	
81. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		82. DECEASED'S USUAL PLACE OF DEATH Home		83. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		84. DECEASED'S USUAL PLACE OF DEATH Home		85. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
86. DECEASED'S USUAL PLACE OF DEATH Home		87. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		88. DECEASED'S USUAL PLACE OF DEATH Home		89. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		90. DECEASED'S USUAL PLACE OF DEATH Home	
91. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		92. DECEASED'S USUAL PLACE OF DEATH Home		93. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		94. DECEASED'S USUAL PLACE OF DEATH Home		95. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery	
96. DECEASED'S USUAL PLACE OF DEATH Home		97. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		98. DECEASED'S USUAL PLACE OF DEATH Home		99. DECEASED'S USUAL PLACE OF BURIAL St. Mary's Cemetery		100. DECEASED'S USUAL PLACE OF DEATH Home	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
12965					CERTIFICATE OF DEATH					12951									
										Reg. Dist. No.									
1. PLACE OF DEATH o. COUNTY <u>QUEEN ANNE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>					c. LENGTH OF STAY IN 1b <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS <u>R.D. 1 Box 130</u>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>RICHARD</u> First <u>LEON</u> Middle <u>WILLIAMS</u> Last					4. DATE OF DEATH <u>NOVEMBER 24</u> Month <u>1959</u> Year														
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1 OCTOBER 1959</u>		9. AGE (In years lost birthday) yrs. <u>1</u> Months <u>24</u> Days <u>24</u> Hours <u></u> Min. <u></u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>DANIEL</u> <u>WRIGHT</u>					14. MOTHER'S MAIDEN NAME <u>ELVA A. WILLIAMS</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>none</u>					INFORMANT <u>ELVA A. WILLIAMS</u> Address <u>R.D. 1, Box 130, CENTREVILLE</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>772.0</u> DUE TO <u>MALNUTRITION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>11/24</u> , 19 <u>59</u> , to <u>11/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>105 Chesterfield Ave. Centreville, Maryland</u>					DATE SIGNED <u>Arthur L. Hume</u>				
ACTUAL SIGNATURE <u>J. Kent Young</u>					M.D. <u></u>														
PHYSICIAN'S NAME (Type) <u>J. KENT YOUNG</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>NOV-25-59</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Roseville</u>					22d. LOCATION (City, town, or county) (State) <u>No Price Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Burtin</u>					ADDRESS <u>Burtin Bros. Centreville Md.</u>					24a. REC'D BY REGISTRAR <u>NOV 25 '59</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>				

2080172XV3

DATE 10-10-2010 BY 60322 UCBAW/STP

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